PFS. Monthly resource utilisation associated with PFS and progression was estimated by a consensus panel of UK experts. Cost of AEs and drug-administration costs were also included. The evaluation accounted for longer treatment duration (24%) with erlotinib compared to docetaxel (mean duration 125 vs. 101 days, respectively). The incremental drug acquisition cost for erlotinib vs docetaxel was consequently £1867. The primary outcome was total direct NHS costs and QALYs. **RESULTS:** Total direct NHS costs were £12,701 and £12,621 for erlotinib and docetaxel, respectively. Erlotinib vs docetaxel offers a cost saving of £971/patient due to its oral administration and £301/patient in the management of AEs. QALYs were 0.201 and 0.176 (erlotinib vs docetaxel, respectively). The ICER for erlotinib vs docetaxel was estimated at £3354. Erlotinib was cost-effective whether or not the calculation assumed improvements in PFS. Improvements in QoL and reduced toxicity with erlotinib led to greater total QALYs vs docetaxel. **CONCLUSIONS:** Erlotinib is a valuable alternative to docetaxel in relapsed NSCLC. Efficacious without compromising QoL and well tolerated, erlotinib can be considered a highly cost-effective treatment for NSCLC in the UK. Orally administered, it may also be associated with a capacity benefit to the NHS through reduction in existing infusion and outpatient requirements.

HEALTH CARE USE & POLICY STUDIES

HP1

CRITICAL APPRAISAL OF ECONOMIC EVALUATIONS OF CHOLESTEROL LOWERING DRUGS: A SYSTEMATIC REVIEW

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OBJECTIVES: The large availability of economic evaluations and their increasing importance for decision making emphasizes the need for economic evaluations that are methodologically sound. The aim of this study is to provide users of economic evaluations of cholesterol lowering drugs with an insight into the quality these evaluations. By focussing on the most relevant studies the gap between research and policy making may be narrowed. **METHODS:** A systematic review was conducted. All publications on economic evaluations of cholesterol lowering drugs were identified by searching Pub Med, the Centre for Reviews and Dissemination database (CRD), the National Health Service Economic Evaluation Database (NHS EED), the Health Technology Assessment database (HTA) and the Database of Abstracts of Reviews of Effects (DARE). A search strategy was set up to identify the articles to be included. These articles were quality assessed using Drummond's checklists. The scoring was performed by at least two reviewers. When necessary, disagreement between these reviewers was decided upon in a consensus meeting. We calculated an average quality score for the included articles. **RESULTS:** The search identified 23 articles that were included. Most studies measured the costs/LYG. The overall score per study varied between 2.7 and 7.7 with an average of 5.4. Most studies score high on the measurement of costs and consequences whereas the establishment of effectiveness leaves room for improvement. Only two studies included a well performed incremental analysis. **CONCLUSION:** This review noticed an increase of quality of economic evaluations over time. Consequently, the value of cost-effectiveness studies for policy decisions increases over time. In general piggy back evaluations tend to score higher on quality and are therefore more valuable in decisionmaking.

HP2

TRENDS IN ANGIOTENSIN II RECEPTOR BLOCKER (ARB) PRESCRIBING AMONG GENERAL PRACTITIONERS IN THE UK

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OBJECTIVES: ARBs were introduced into the UK antihypertensive drug market with conflicting data on their relative effectiveness compared to other classes, which offered lower cost alternatives. The study aim was to determine patient-level characteristics of ARB prescribing patterns and how these changed over time since the first ARB market launch December 1994. **METHODS:** The study population was identified from the Health Improvement Network (THIN) database, an electronic medical record dataset of patients seen by general practitioners in the UK. Patients who received an oral drug approved for hypertension treatment at any point in time from 1995 through 2003 were included. The multinomial logit model was applied to two time periods to predict the likelihood of receiving an ARB prescription compared to other antihypertensive drug classes, after controlling for patient characteristics. A time dummy tested for changes between the time periods. **RESULTS:** Immediately after the first ARB introduction (1995–1997), 0.25% (N = 537,309) of the study population was allocated to ARB therapy. This rose to 6.22% (N = 803,981) for the more recent time period (2001–2003). In the early time period, patients with high blood pressure readings and patients seen by a Cardiologist were more likely to receive prescriptions for ARBs than other antihypertensive classes. This did not persist for the more recent time period. Over time, prescribing antihypertensive drugs for patients with diabetes shifted away from all classes ($P < 0.01$), except the angiotensin converting enzyme inhibitor (ACEi) class ($P = 0.6334$), towards ARB prescribing. For patients with heart failure, there was a statistically significantly shift away from prescribing ARBs towards the beta-blocker and "Other" classes. In general, patients with diabetes or heart failure were more frequently prescribed ACEi than ARB therapy. CONLUSIONS: ARBs were prescribed cautiously in the UK and ARB prescribing patterns altered over time as new safety and effectiveness evidence emerged.

HP3

THE ROLE OF GENERAL PRACTITIONERS IN THE INITIAL MANAGEMENT OF WOMEN WITH URINARY INCONTINENCE IN FRANCE, GERMANY, SPAIN AND THE UK

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OBJECTIVES: To describe the role of general practitioners (GPs) in the initial management of women with UI in 4 European countries with different health care systems. **METHODS:** Cross-sectional community postal survey of 2,953 community-dwelling women with UI in France, Germany, Spain and the UK. **RESULTS:** There was an overall response rate of 53% (n = 1573). Forty eight percent had discussed their UI with a doctor. More women discussed UI in France and Germany than in the UK and Spain. The patient usually raised the issue, during consultations for some other reason. Fear of, or actual deterioration in UI was the most important reason for discussing UI. Overall 52% of incontinent women first discussed their UI with a GP and almost a third of women reported having all their UI discussions in a GP setting. Twenty nine per cent of women reported that GPs had either recommended treatment or monitoring of their condition before beginning treatment and 24% reported